

¡SALUD! Health Promotion Sleep Assessment

Name: _____ SS#: ____/____/____ Date: __/__/__

Mail Stop: _____ Email: _____ Phone: _____ ☐ Male ☐ Female Age: ____

Please list any medications, supplements or vitamins, *prescribed or over the counter*, you are currently using on a regular basis for any condition:

Please list any medications, supplements, vitamins, oxygen, CPAP, nasal strips, dental devices etc. that you use to improve your sleep:

On average how many beverages containing caffeine do you consume a day? _____

Count an 8oz. serving as one beverage. For example: one can of soda is 12oz. which = 1 ½ beverages.

(Examples of beverages containing caffeine include: regular and diet colas, other soft drinks like Mountain Dew, orange soda, regular hot and iced tea including green and black tea, as well as regular coffee beverages.)

Have you ever had a sleep study? YES NO

Sleep History

Please answer each of the questions below by circling your response or filling in the blank.

Sleep Quality

In general, would you describe your sleep as:	REFRESHING	NOT REFRESHING
What is the QUALITY of your sleep?	Extremely Good Very Good Good Adequate Fair Poor Very Poor Extremely Poor	
On a scale of 0 to 10, how SLEEPY are you during the day?	Not Sleepy 0 1 2 3 4 5 6 7 8 9 10 Extremely Sleepy	
On a scale of 0 to 10, how TIRED are you during the day?	Not Tired 0 1 2 3 4 5 6 7 8 9 10 Extremely Tired	

Sleep Habits & Insomnia

On average, how long does it usually take you to FALL ASLEEP?	_____ Minutes _____ Hours	
On average, how many HOURS OF SLEEP do you usually get in a night?	_____ Hours	
On average, how many HOURS IN BED do you usually spend in a night?	_____ Hours	
Do you WAKE UP a lot during your sleep? If yes, how many times per night on average? _____	YES	NO
If awakened, do you have trouble RETURNING to sleep?	YES	NO
If awakened, how much TIME AWAKE do you spend at night trying to get back to sleep?	_____ Minutes _____ Hours	

Sleep History Continued...**Sleep and Breathing**

	Would you or others say you SNORE LOUDLY?	YES	NO
	Have you or others MOVED from the bed/bedroom because of your snoring?	YES	NO
	Would you or others say that you have other TROUBLE BREATHING while you sleep, such as stop breathing, choking, gasping, or struggling for breath?	YES	NO

Sleep and Leg Movements

	While lying still in bed, do you have UNCOMFORTABLE SENSATIONS in your legs that prevent you from sleeping?	YES	NO
	If yes, do these SENSATIONS GO AWAY when you move your legs?	YES	NO
	Would you or others say that you TWITCH or JERK your legs while you sleep?	YES	NO
	Have you or others ever MOVED from your bed/bedroom because of your twitches or leg jerks?	YES	NO

Review of Systems: CIRCLE any symptom that you've been having at least WEEKLY during the past month:

- | | |
|---|--|
| <input type="checkbox"/> Wake up with dry mouth | <input type="checkbox"/> Difficulty with memory |
| <input type="checkbox"/> Problems controlling your blood pressure | <input type="checkbox"/> Feeling anxious |
| <input type="checkbox"/> Morning headaches | <input type="checkbox"/> Feeling depressed |
| <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Disturbing dreams or nightmares |

CIRCLE any of the items listed below that wake you up or keep you from sleeping:

- | | |
|--|--|
| <input type="checkbox"/> Restless legs or leg jerks | <input type="checkbox"/> Pain |
| <input type="checkbox"/> Trouble breathing | <input type="checkbox"/> Racing thoughts/ Can't turn off your mind |
| <input type="checkbox"/> Indigestion/ Reflux | <input type="checkbox"/> Anxiety or fear about something |
| <input type="checkbox"/> Needing to use the bathroom | <input type="checkbox"/> Needing a drink of water |

Summary of Sleep Problems

Sleep Problem (Circle all that apply to you)	Duration (indicate the period of time that you have suffered from all of the sleep problems that you have circled)
Insomnia	_____ Months _____ Years
Nightmares	_____ Months _____ Years
Poor Sleep Quality	_____ Months _____ Years
Sleep Breathing Problem	_____ Months _____ Years
Sleep Movement Problem	_____ Months _____ Years
Other: _____	_____ Months _____ Years

Insomnia Severity Index

Please answer each of the questions below by circling the number that best describes your sleep patterns **in the past week**. Please answer all questions.

	Please rate the current (past week's) SEVERITY of your insomnia problem(s):	None	Mild	Moderate	Severe	Very Severe
	Difficulty falling asleep:	0	1	2	3	4
	Difficulty staying asleep:	0	1	2	3	4
	Problem waking up too early:	0	1	2	3	4

	How SATISFIED/DISSATISFIED are you with your current sleep pattern?	Very Satisfied 0	? 1	? 2	? 3	Very Dissatisfied 4
	To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g., daytime fatigue, ability to function at work/daily chores, concentration, memory, mood, etc.)?	Not at all Interfering 0	A Little 1	Some What 2	Much 3	Very Much Interfering 4
	How NOTICEABLE to others do you think your sleeping problem is in terms of impairing the quality of your life?	Not at all Noticeable 0	A Little 1	Some What 2	Much 3	Very Much Noticeable 4
	How WORRIED/DISTRESSED are you about your current sleep problem?	Not at all 0	A Little 1	Some What 2	Much 3	Very Much 4

Total: _____

Epworth sleepiness scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to circle the *most appropriate number* for each situation:

Situation:	Chance of dozing:			
	0 would never doze	1 <i>slight</i> chance of dozing	2 <i>moderate</i> chance of dozing	3 <i>high</i> chance of dozing
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (e.g. a theater or meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in the traffic	0	1	2	3

Total: _____

Sleep Hygiene

Do you awaken at the same time each day?	YES	NO	
Do you participate in regular exercise at least 3 days a week?	YES	NO	
If you exercise, do you exercise at least 4 hours prior to going to bed?	YES	NO	Don't Exercise
If you nap, do you nap only early in the day for no more than 20 minutes?	YES	NO	Don't Nap
Do you have a comfortable sleep environment? This means an environment that includes; a comfortable bed, comfortable bedroom temperature, a clean, quiet and darkened bedroom.	YES	NO	
Do you have techniques or rituals to help you relax at bedtime? Such as: taking a warm bath, listening to relaxing music, deep breathing, or imagery?	YES	NO	
Do you expose yourself to sunlight each morning?	YES	NO	
Do you smoke less than 2 hours before going to bed?	YES	NO	Don't Smoke
Do you check the time if you awaken at night?	YES	NO	Don't Usually Wake Up
Do you drink more than 2 cups of coffee or other caffeine containing beverages per day?	YES	NO	Don't Drink Caffeine Containing Beverages
Do you drink alcohol within 2 hours of going to bed?	YES	NO	Don't Drink Alcohol
Do you eat large meals within 3 hours of going to bed?	YES	NO	
Do you go to bed when you are not "sleepy"? In other words, do you go to bed based on the time, boredom, or because you think you should?	YES	NO	
Do you use your bedroom for activities other than sleep or sex? Such as: watching TV, paying bills, discussing the problems of the day, studying or work activities or do you have an office in your bedroom?	YES	NO	

Stanford Presenteeism Scale (SPS 6) Form

Below we would like you to describe your work experiences in the past month. These experiences may be affected by many environmental as well as personal factors and may change from time to time. For each of the following statements, please select one of the following responses to show your agreement or disagreement with this statement in describing your work experiences in the past month. (Note: The words "chronic stress," "back pain," "cardiovascular problem," "illness," "stomach problem," or other similar descriptors can be substituted for the words "health concern" in any of these items.)

		Strongly Disagree	Somewhat Disagree	Uncertain About Agreement	Somewhat Agree	Strongly Agree
1.	Because of my health concern, the stresses of my job were much harder to handle.					
2.	Despite having my health concern, I was able to finish hard tasks in my work.					
3.	My health concern distracted me from taking pleasure in my work.					
4.	I felt hopeless about finishing certain work tasks, due to my health concern.					
5.	At work, I was able to focus on achieving my goals despite my health concern.					
6.	Despite having my health concern, I felt energetic enough to complete my work.					

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